The California Managed Risk Medical Insurance Board
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August 16, 1999

Governor Gray Davis, Members of the California Legislature
and Fellow Californians:

The Managed Risk Medical Insurance Board (MRMIB) is pleased to present the 1999 Fact Book for the Major Risk Medical Insurance Program (MRMIP). The purpose of this report is to inform you of the activities, progress and accomplishments of the MRMIP.

MRMIP, the State's high-risk insurance pool, was the first program developed and administered by the MRMIB. The MRMIP was established in January 1991 to respond to the legislative finding that many Californians do not have employer-sponsored group health coverage and are unable to secure adequate health coverage for themselves and their dependents because of pre-existing medical conditions.

The MRMIP is currently providing health insurance to over 21,000 individuals. Since its inception, MRMIP has served 57,992 Californians who were faced with chronic illnesses, were unable to purchase private health coverage, and who faced financial ruin due to their health care needs.

The MRMIB is dedicated to improving the health of Californians by increasing access to affordable, comprehensive, quality health care coverage. Future goals for the MRMIP include identification of an expanded long-term funding source and identification of market reform strategies that will eliminate the need for the program.

MRMIB looks forward to continuing to bridge gaps in health care coverage for this very special population. We hope that the success, opportunities and limitations of this program will be kept in mind as you consider various proposals for reforming our health care system, and expanding coverage to individuals who are uninsured.

Sincerely,

Sandra Shewry

Sandra Shewry
Executive Director

Table of Contents

OVERVIEW OF THE MAJOR RISK MEDICAL INSURANCE PROGRAM

The Major Risk Medical Insurance Program (MRMIP), the State's high-risk insurance pool, provides health coverage to individuals who are unable to purchase private coverage because the insurance industry views them as uninsurable. Medically uninsurable individuals typically have or have had chronic illnesses (such as heart disease or cancer) that are associated with intensive treatment, specialized and frequent care, often resulting in high health care costs. Individuals participating in the MRMIP have either been denied individual coverage or are unable to afford the coverage that is available to them. One of the main barriers individuals face in gaining access to health insurance in California is the underwriting and premium pricing practices of health insurers and health plans. This may make health insurance unavailable or unaffordable for some persons with chronic and other health conditions[1].

The MRMIP provides comprehensive benefits to subscribers and their dependents. Two Preferred Provider Organizations (PPOs) and five Health Maintenance Organizations (HMOs) participate in the program, giving members a choice of two or more health plans in all but the most rural areas of the state. Subscribers in the MRMIP are charged a monthly premium ranging from 125 to 137.5 percent of each participating plan's standard average individual rate. The premiums are subsidized by the State through the Cigarette and Tobacco Surtax Fund (Proposition 99). Because the appropriation from the Cigarette and Tobacco Surtax Fund is limited, the program is restricted in the total number of individuals who can participate.

The MRMIP began serving members in January 1991, and has served 57,992 individuals since its inception. The demand for the program has consistently exceeded the program's capacity and as such, the program maintains a waiting list for new subscribers. Subscribers typically experience a three to six month waiting period before entering the program. Since 1994, individuals waiting to enter the program have had access to a MRMIP “look-alike" program offered by two plans participating in the MRMIP. Premiums for the MRMIP look-a-like program are not subsidized by the State.

California is one of 28 states operating a high-risk health insurance pool. MRMIP is the second largest pool in the country, exceeded only by Minnesota, which has an enrollment of 26,000. It is estimated that approximately 41 million Americans, or 17.7 percent of the nation’s population, are uninsured at any given time. Of this, about one percent are both uninsured and uninsurable[2]. Based on this estimate, over 300,000 Californians may be uninsurable, uninsured and eligible for the Major Risk Medical Insurance Program.

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[1] Schauffler H., Ph.D., MSPH, Brown R., Ph.D., McMenamin S., MPH, Rice T., Ph.D Cubanski J., MPP. State of Health Insurance in California, 1998. Berkeley, CA. Regents of the University of California. 1999. p. 40.

[2] Communicating for Agriculture. The Comprehensive Health Insurance for High-Risk Individuals, Twelfth Edition, Inc. 1998. p. 6.

Milestones of the Major Risk Medical Insurance Program

1991: MRMIP became operational in late January with 400 subscribers, and an annual appropriation of $30 million from the Cigarette and Tobacco Surtax Fund. A maximum enrollment level of 10,000 was established to ensure that the program would operate within its budget. Annual benefits were capped at $50,000 with a lifetime maximum of $500,000. By December 1, 1991, the maximum enrollment capacity had been reached and 3,464 applicants were placed on a waiting list.

1992: The waiting list grew to 4,200 applicants in December. The waiting time for entry into the program was approximately 12 months. By the end of the year, the average cost per person was found to be lower than anticipated and the enrollment cap was increased to 14,100 individuals.

1994: Blue Cross of California established a MRMIP look-alike program which allowed applicants on the MRMIP waiting list to purchase coverage at unsubsidized rates until they could be admitted to the program.

1996: To help offset the increase in program costs, subscriber contributions were increased up to 10 percent for those individuals who selected health plans requiring a higher than average subsidy from the Cigarette Tobacco Surtax Fund.

1997: An additional $10 million in annual Tobacco Tax revenue was appropriated for MRMIP bringing the total appropriation to $40 million. Blue Shield of California introduced a MRMIP look-alike program to serve persons on the waiting list.

1998: The enrollment level was increased to 21,900 persons.

1999: The maximum benefit and lifetime cap for the program increased to $75,000 and $750,000 respectively. For the first time, the program's maximum enrollment level was reduced--to 21,124. This reduction was the result of program benefit levels being increased, health care cost inflation and the fixed appropriation available for the program. One-time funding of two million dollars was provided by the California HealthCare Foundation to ameliorate the enrollment reduction. This grant preserved 448 enrollment spaces in the MRMIP.

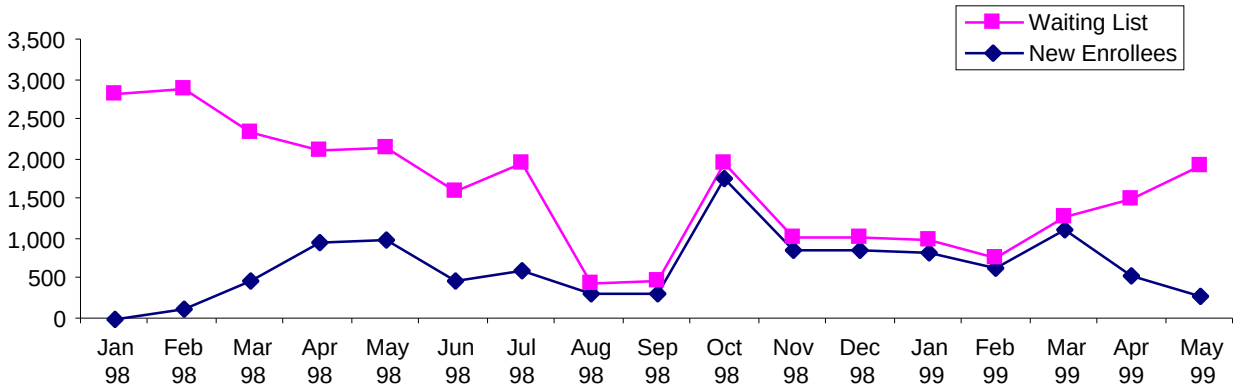
MRMIP Maximum Enrollment Levels: 1991 to Present

Dec-91	10,000
Jan-92	11,200
Jan-93	14,000
Sep-93	16,400
May-94	18,040
Nov-94	19,535
Jul-97	19,917
Jun-98	21,900
May-99	21,124

DEMAND FOR THE MRMIP

There is consistent, strong demand for the MRMIP. The program routinely operates at maximum enrollment capacity and maintains a waiting list of persons wanting to enter the program. Persons on the MRMIP waiting list are enrolled in the program in the order their application was received. While on the waiting list, applicants may purchase coverage through a MRMIP look-alike plan from Blue Cross of California or Blue Shield of California, two of the health plans participating in MRMIP. These look-alike plans are modeled after MRMIP but are not subsidized. Subscribers must pay the full cost of the insurance policy. Approximately 80 percent of the people on the MRMIP waiting list chose to purchase a MRMIP look-alike plan. From January 1998 to May 1999 the average number of people on the waiting list was 949. Even though there is no attempt made to market the MRMIP, the waiting list continues to replenish, indicating continuous demand for the program.

Number of New MRMIP Enrollees and Persons on the Waiting List



Source: MRMIP Enrollment Data, 1998-1999

In May 1999, enrollment levels were reduced for the first time in the program's history. Enrollment capacity in the program was reduced from 21,900 to 21,124. This reduction was the result of program benefit levels being increased from $50,000 to $75,000 in January 1999, the fixed $40 million appropriation for subsidy funds, and health care cost inflation.

Decreases in the program's maximum enrollment level are expected to continue unless additional subsidy funds are identified or program costs are reduced. Given the fixed number of State dollars that are available for the MRMIP, the program has only been able to assist a small number of Californians who may be uninsurable and eligible for the MRMIP.

Without MRMIP, current subscribers would likely suffer from poor health status or become eligible for the Medi-Cal program after depleting their family resources to pay for their health care needs. Given the expected reduction in MRMIP enrollment levels, options for either the elimination or significant reduction of the need for the program, or alternative funding sources should be explored.

Eliminate The Need For The MRMIP

To eliminate the need for the MRMIP, the State would have to open the individual insurance market to all persons seeking to purchase coverage. This could be accomplished by reforming State insurance laws to provide guaranteed issuance of policies. Insurers have long resisted the provision of guaranteed issuance in the individual market, citing concerns with adverse selection. To address these concerns, reform advocates have proposed several mechanisms to ameliorate adverse selection. These include limiting the guaranteed issuance rights of individuals to the month of their birthday, or requiring persons to be enrolled in the MRMIP or be put on the waiting list for a period of time prior to entering the individual insurance market.

Utilize Alternate Funding Sources

- **Increased Commitment of State Funds**
  The primary source of funding for the MRMIP has been from Cigarette and Tobacco Surtax (Prop. 99) revenues. As Prop. 99 revenues decline, sustaining or increasing the current $40 million appropriation would come at the expense of other Prop. 99 programs. Alternatively, State general funds could be provided to the MRMIP. California is one of five states that allocates general revenues, income tax revenues or tobacco tax revenues to their high-risk pools.

  The tenet behind state funding for MRMIP is the belief that the State has a role in subsidizing insurance coverage for persons with pre-existing health conditions, leaving the individual insurance market to serve those persons identified by the market as “good risks”. The assumption of costs by the State for persons with pre-existing health conditions is assumed to preserve the viability of the individual insurance market for individuals who are not high-risk.

- **Assessment of Health Insurers**
  This is the most common option used by states to fund their high-risk pools. Under this approach, all commercial insurers are assessed to fund the subsidy needed to cover all high-risk pool subscribers. The Federal Employee Retirement Income Security Act (ERISA) provisions would require the State to exempt self-insured plans. Therefore, the financial burden to fund the high-risk subsidy would fall on individuals and groups purchasing insurance through the commercial market.

- **Assessment on Health Insurers with a Tax Credit**
  Under this approach, insurers are assessed for the costs of the program, but the assessments to insurers are offset by premium taxes or income taxes paid by insurers. Variations of this approach include placing a cap on the amount of the assessment that could be offset in any year, or establishing a minimum assessment amount that must be paid prior to the tax credit being

granted. The tax credit would apply only to amounts above the minimum assessment.

- **Service Charge on Health Care Providers**
  Under this approach, a surcharge is placed on health care providers to fund the risk pool. In Minnesota, a surcharge of $2 per hospital day and $1 per ambulatory surgical center admission is used to fund the state's high-risk pool and MinnesotaCare, a low income subsidy program. An advantage to this approach is that the assessment burden is widely spread throughout the health care delivery system. In addition, persons covered under ERISA plans are indirectly included in the assessment formula. The chart below summarizes the methods states use to fund their high-risk pools.

Sources of Funding Used by States with High-Risk Pools

State	Allocation of State Funds	Assessment of Health Insurers	Assessment of Health Insurers with Tax Credit	Other
Alabama			X	
Alaska		X		
Arkansas		X		
California	X			
Colorado				Unclaimed Property Fund
Connecticut		X		
Florida		X		
Illinois	X			
Indiana		X		
Iowa		X		
Kansas			X	
Louisiana	X			Service charge on providers
Minnesota				Service charge on providers
Mississippi		X		
Missouri			X	
Montana			X	
Nebraska			X	
New Mexico			X	
North Dakota			X	
Oklahoma			X	
Oregon	X	X		
South Carolina			X	
Tennessee	X			
Texas		X		
Utah	X			
Washington			X	
Wisconsin		X		
Wyoming			X	

Source: Communicating for Agriculture. The Comprehensive Health Insurance for High-Risk Individuals, Twelfth Edition, Inc. 1998. p. 17-27.

Lower Program Costs

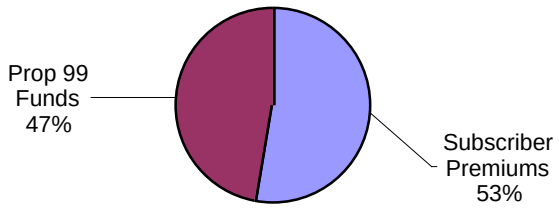
An alternative to increasing funding for the program, or eliminating the need for the MRMIP, is to lower program costs. This could be accomplished through reducing the maximum annual benefit level, eliminating specific benefits, reducing provider payment levels or through increasing the percentage of costs paid by subscribers. None of these options are considered to be feasible at this time.

ADMINISTRATION OF THE MRMIP

Funding

MRMIP revenues are derived from subscriber premiums and subsidies from the Cigarette and Tobacco Products Surtax Fund (Proposition 99). The total revenue for FY 1998-1999 is $85 million. Over half of program revenues are from subscriber premiums.

1998-1999 MRMIP Funding



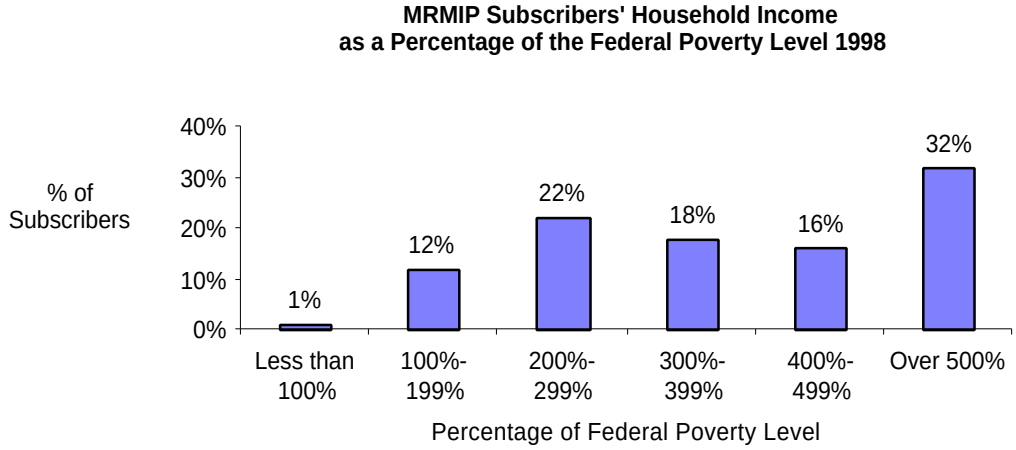
Source: MRMIP State Cash Flow Analysis for Fiscal Year 1998-1999

Subscriber premiums are established through a multi-step process, and are based on current market prices for individual private insurance coverage. Each participating health plan's price for the MRMIP benefit package is calculated and is then multiplied by a factor of between 125 and 137.5 percent to determine the monthly premium amount. The factor that is used to multiply each plan's premium is determined by the average amount of subsidy funds that are required by the plan. If the plan requires subsidy funds at or below the program average subsidy, the plan's prices are multiplied by 125 percent. If the plan requires higher than average subsidies, the plan's prices may be multiplied by up to 137.5 percent. This variation provides an incentive for MRMIP members to select those plans that require no more than the average subsidy.

Household Income and Premiums Paid by Subscribers

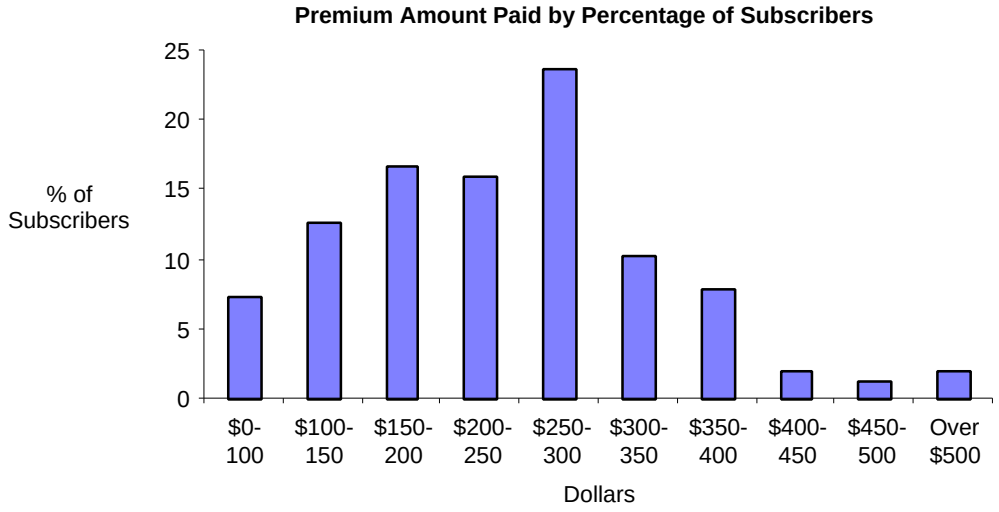
Sixty-eight percent of MRMIP subscribers have a family size of two or less. Two-thirds of subscribers live in households with incomes of 300 percent or more of the federal poverty level. One in three subscribers have incomes over 500 percent of the federal poverty level. It is believed that there are few subscribers in MRMIP with low incomes because they may be eligible for share of cost Medi-Cal. Also, the premiums required for the program necessitate income levels higher than what is present in other state- subsidized health programs.

In 1998, the 200 percent federal poverty level was $21,700 for a family of two.



Source: MRMIP 1998 Independent Survey

The average premium paid by MRMIP subscribers in 1998 was $255 per month. This amount equals 8.31 percent of subscribers' household incomes. In 1998, subscribers contributed $45 million to the cost of the MRMIP.



Source: MRMIP Enrollment Data 1998

Program Expenditures

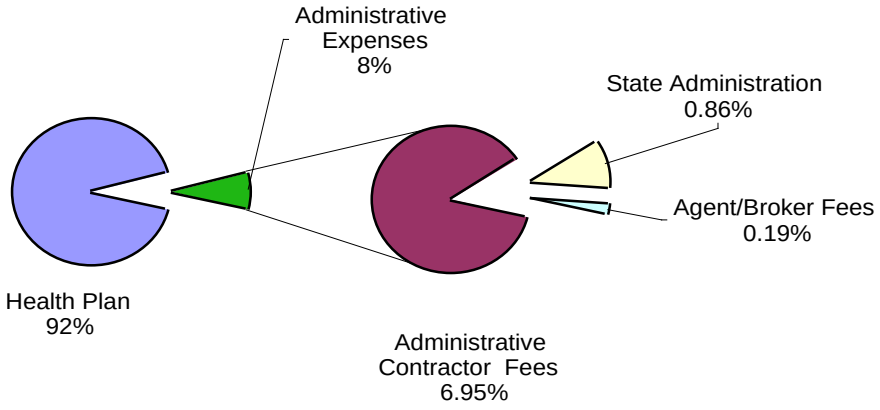
There are three categories of expenditures budgeted for MRMIP funds in FY 98-99.

These expenditures are:

- State administrative costs.
- Payments to the administrative contractor, Blue Cross of California, for eligibility determination, enrollment services, premium collection on behalf of health plans and payments to insurance agents and brokers. Blue Cross of California is paid a flat fee per application plus a monthly premium collection fee for all enrolled subscribers.
- Health care costs.

Ninety-two percent of the program dollars are projected to be spent on health plan costs for program subscribers in FY98-99. Eight percent of program funds are expected to be spent on administrative expenses. These expenses include: state administrative costs (.86 percent); administrative contractor fees (6.95 percent); and agent/broker fees (.19 percent).

MRMIP Projected Program Expenditures for 1998-99



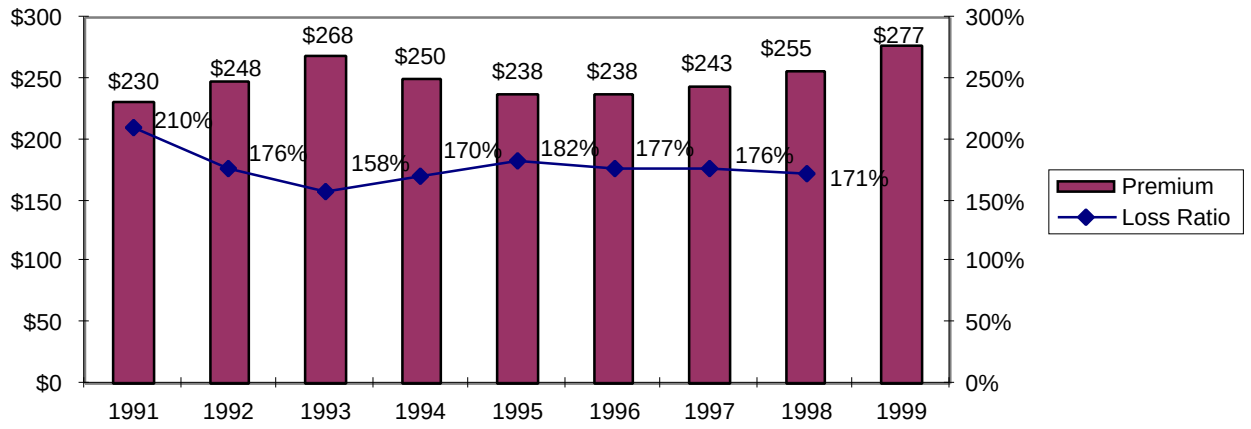
Source: MRMIP State Cash Flow Analysis for Fiscal Year 1998-1999

MRMIB has full risk contracts with four of the seven health plans participating in the MRMIP. Ninety-three percent of program subscribers are enrolled in these plans. The MRMIB also has a shared risk arrangement with one health plan and administrative service contracts with two health plans. Full-risk contracts require participating plans to provide all required MRMIP benefits to enrollees for an annually determined, fixed monthly premium paid by the State and enrollees. The shared-risk contract limits the plan's financial risk to pre-determined levels. A handful of MRMIP subscribers are enrolled in this plan. The administrative service contracts contain no financial risk for the health plans and, in essence, the MRMIP rents the medical networks from these plans. Seven percent of MRMIP subscribers are enrolled in plans with administrative service contracts.

Program Loss Ratio

The program loss ratio determines the amount of State funding which is used to subsidize each subscriber. The loss ratio for the MRMIP program was 176 percent in 1997. For every one dollar in premium paid by a subscriber, 76 cents in subsidy funds were needed. Because the loss ratio varies significantly depending on the health plan selected by enrollees, up to an additional 10 percent in subscriber contributions is required from those subscribers selecting plans that require a higher than average subsidy.

Average MRMIP Subscriber Monthly Premiums & Annual Program Loss Ratio



Note: 1998 Loss Ratio is derived from preliminary data
Source: MRMIP Enrollment Data, 1991-1998

INDIVIDUALS ENROLLED IN THE MRMIP

Eligibility Criteria
Individuals must meet four basic criteria to participate in the Major Risk Medical Insurance Program. Individuals must be:

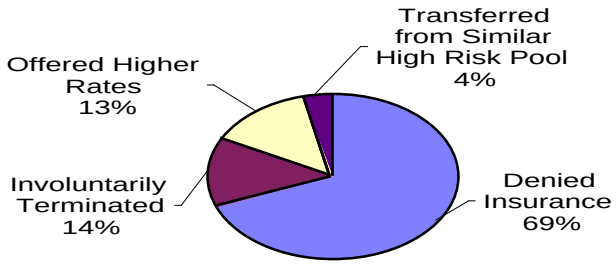
- A resident of California;
- Ineligible for Medicare, Parts A and B, unless they are eligible solely because of end-stage renal disease;
- Ineligible to purchase health insurance for the continuation of coverage through COBRA; and
- Unable to secure adequate health insurance coverage.

Applicants can demonstrate their inability to obtain adequate insurance coverage by documenting that one or more of the following occurred during the previous 12 months:

- Having been denied individual insurance;
- Having been involuntarily terminated for health insurance coverage for reasons other than nonpayment of premium or fraud;
- Having been offered individual coverage at a premium rate higher than those charged by MRMIP;
- Having been covered in a similar high-risk pool sponsored by another state.

Most individuals who are eligible for MRMIP are unable to secure adequate insurance coverage because they have been denied individual coverage.

Reasons Why Subscribers are Eligible for MRMIP: 1997-98

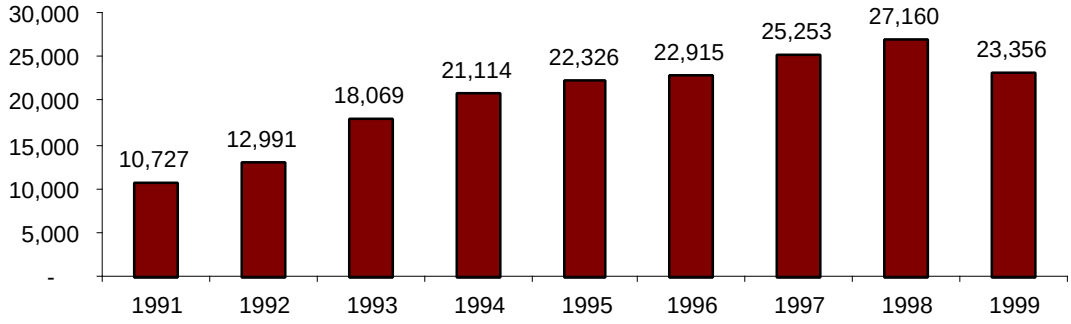


Source: MRMIP Enrollment Data, 1998

Enrollment Statistics

There are over 21,000 subscribers receiving health insurance through the MRMIP as of April 1999. The average length of enrollment in the program is approximately 26 months. Since its inception, MRMIP has served 57,992 Californians.

Number of Persons Ever Enrolled By Year*



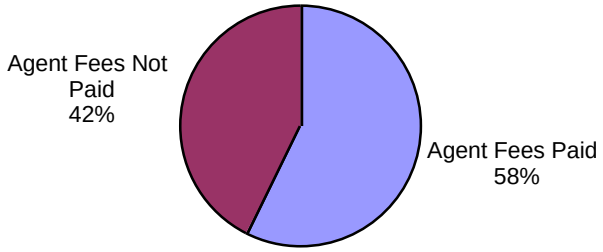
*These numbers represent the number of persons enrolled at any time during the year. Subscribers enrolled in the program more than one year are counted each year.

Source: MRMIP Enrollment Data, 1991-1999

Fifty-eight percent of individuals enrolled in 1998 were referred to the MRMIP by insurance agents. As such, the insurance industry is the largest source of referrals to the program.

MRMIP pays a one-time $50 application assistance fee to insurance agents and brokers who assist applicants in completing their MRMIP applications. Since 1991, 24,118 new subscribers have used an agent or broker for assistance in completing the application.

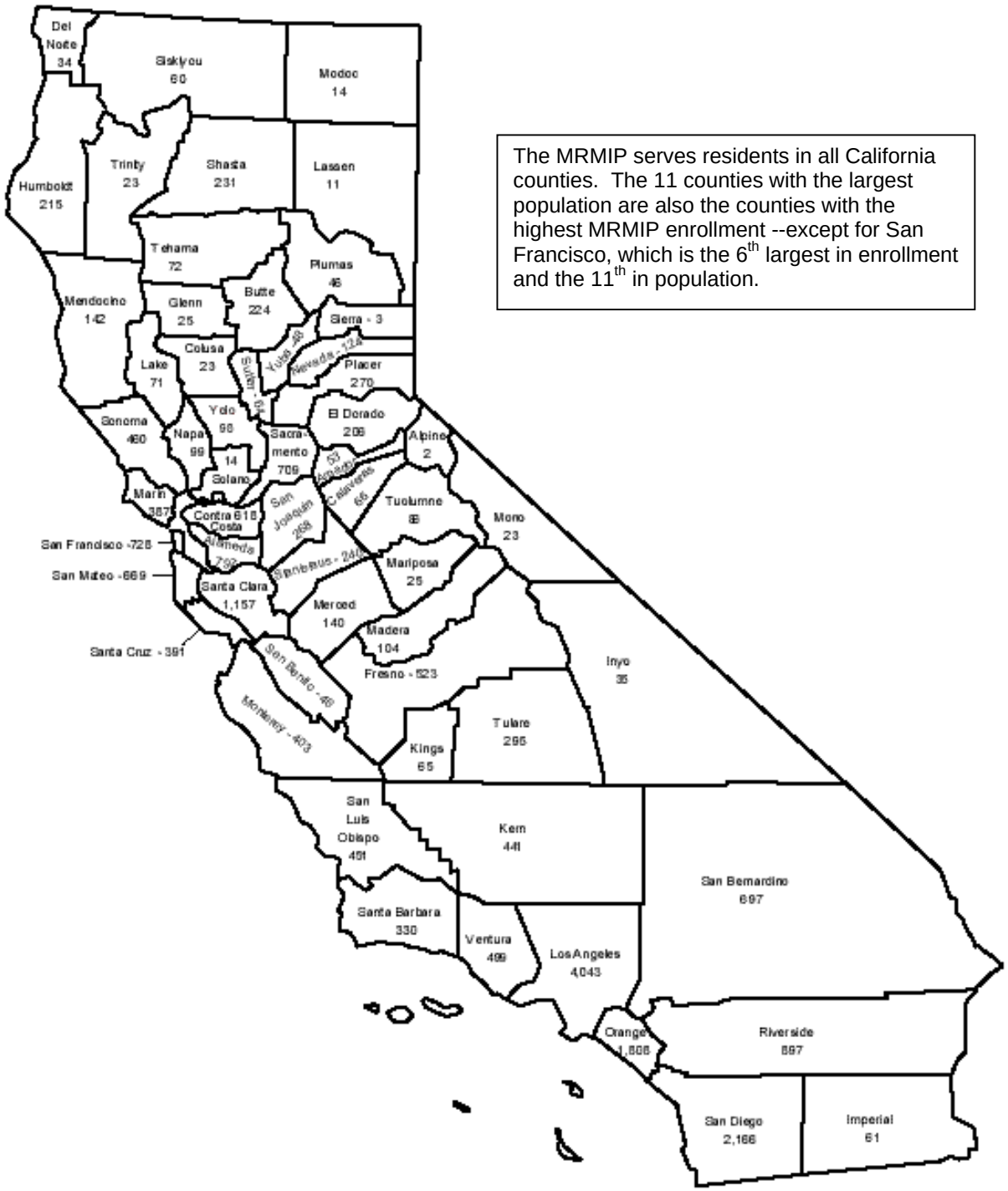
Percentage of Applications for Which an Applicatio Assistance Fee was Paid 1998



Source: MRMIP Enrollment Data, 1998

California MRMIP 1999 Enrollment Distribution

MRMIP enrolls members statewide. This chart shows the distribution of MRMIP subscribers throughout California as of April 1999.



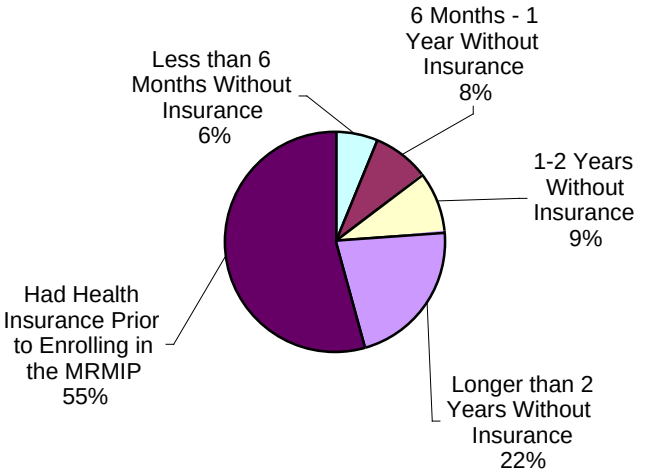
The MRMIP serves residents in all California counties. The 11 counties with the largest population are also the counties with the highest MRMIP enrollment --except for San Francisco, which is the 6th largest in enrollment and the 11th in population.

Source: MRMIP Enrollment Data, 1999

Prior Insurance Coverage

More than half of MRMIP subscribers (55 percent) had health insurance just prior to enrolling in the MRMIP. Thirty-one percent were without insurance for one year or more prior to enrolling in MRMIP.

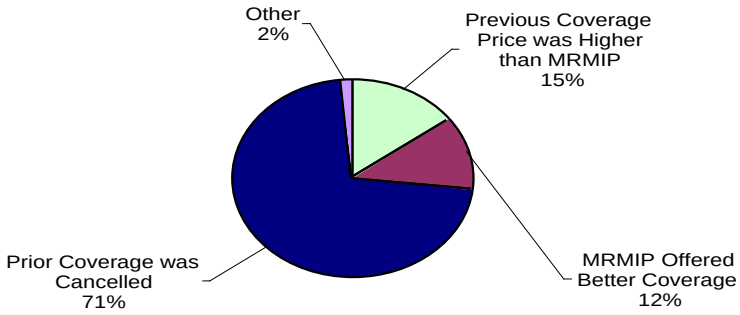
Prior Insurance Coverage Status Prior to Enrolling in MRMIP



Source: MRMIP 1998 Independent Survey

Eighty-six percent of subscribers who had insurance coverage just prior to enrolling in MRMIP switched to MRMIP because their former coverage was no longer available, or was unaffordable.

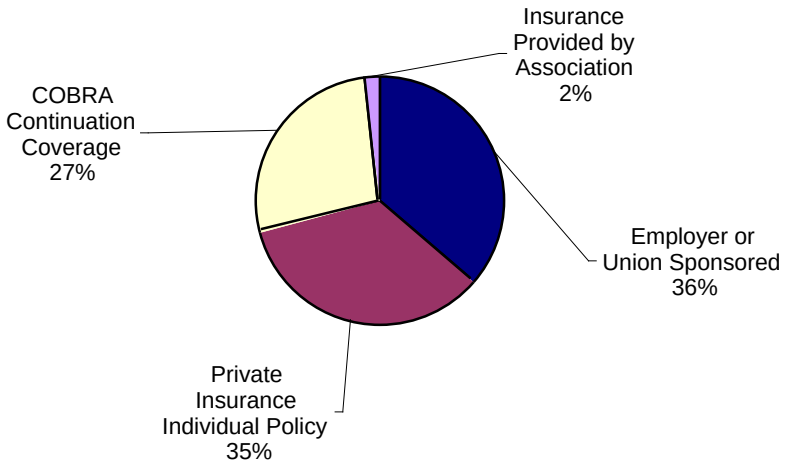
Reasons Why Subscribers Switched to the MRMIP



Source: MRMIP 1998 Independent Survey

Of those subscribers who had prior health insurance, most were either covered by an employer or union, had a private individual policy, or COBRA continuation coverage.

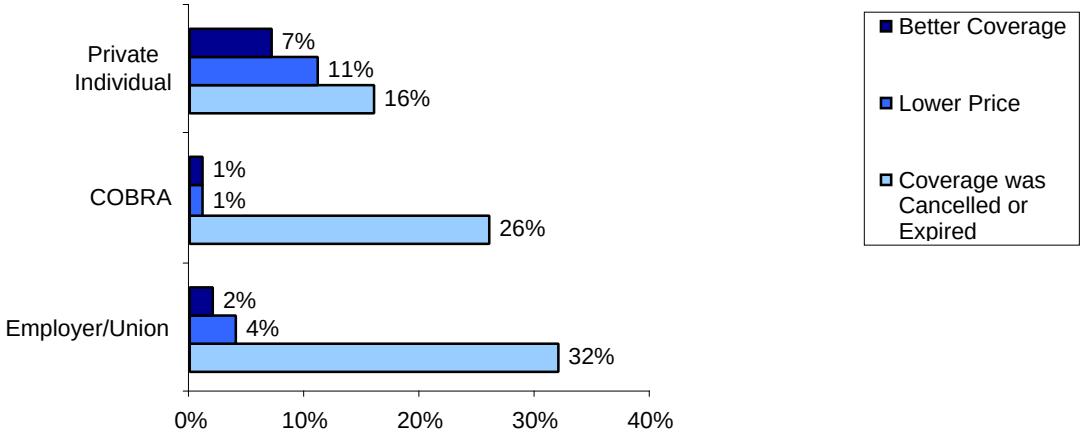
Type of Insurance Subscribers Had Prior to MRMIP



Source: 1998 MRMIP Independent Survey

A higher percentage of subscribers having prior coverage through an individual policy reported that MRMIP had either better coverage or a lower price than their previous insurance. Subscribers who had prior coverage through employer or union plans reported a higher percentage of expired or cancelled insurance in comparison with those having private individual policies.

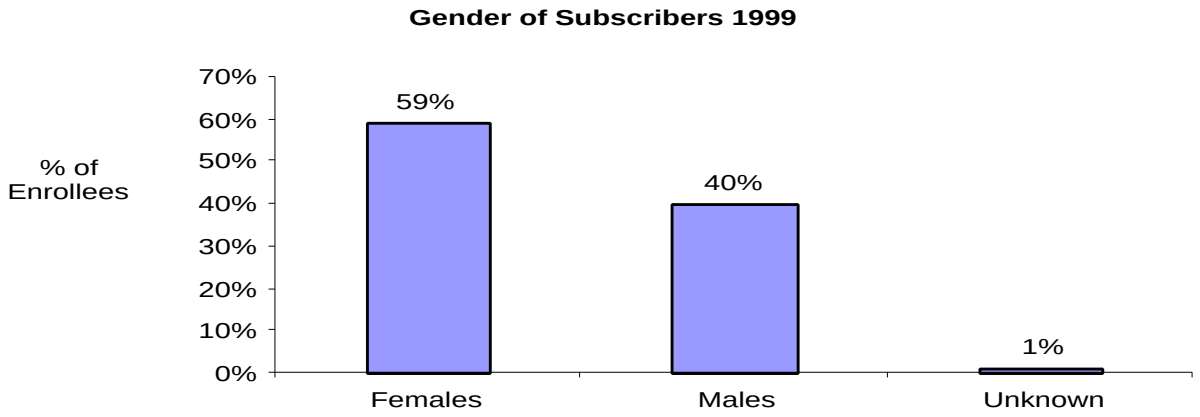
Reasons Subscribers Switched to MRMIP by Type of Prior Insurance



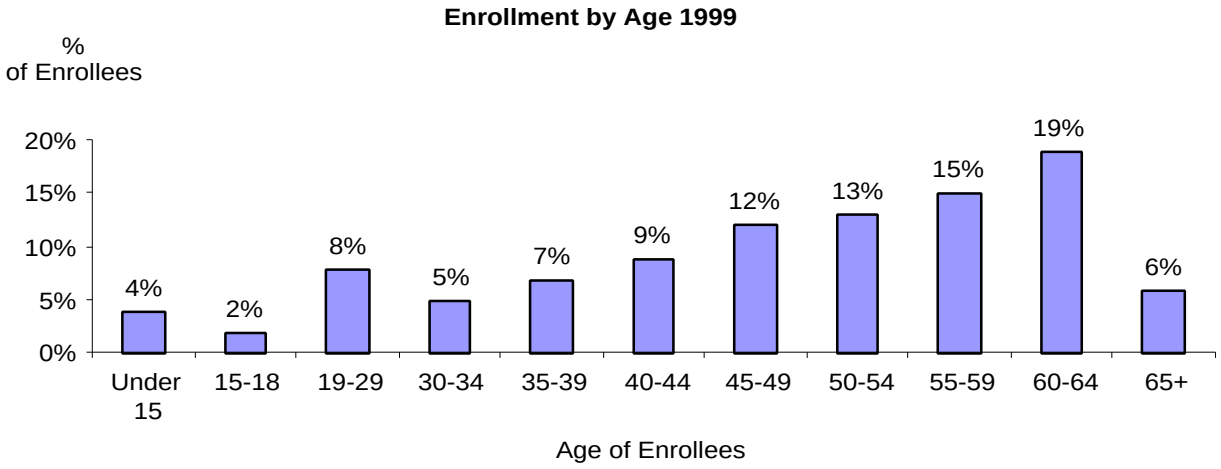
Source: 1998 MRMIP Independent Survey

Age and Gender of Subscribers and Dependents

Most MRMIP subscribers are women and are between the ages of 45 and 64. According to a statewide population survey, one in five Californians ages 40-65 are uninsured. Women are more vulnerable to becoming uninsured because they are more likely to be a dependent on their husband's job-based coverage. If the husband loses his job, dies, or the marriage ends, the woman may automatically lose her insurance coverage [3].



Source: MRMIP Enrollment Data, 1999

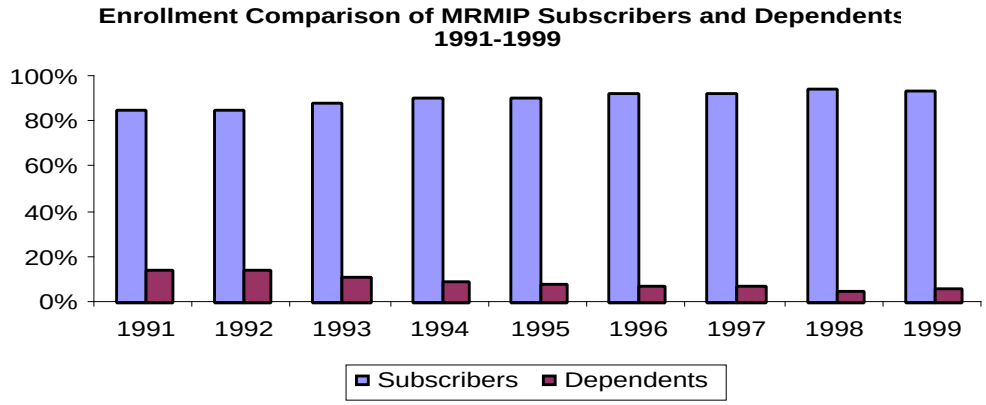


Source: MRMIP Enrollment Data, 1999

Dependents currently comprise 6.4 percent of total enrollment. From December 1992 to present, the percentage of dependents has ranged from a high of 14.5 percent to a low of 6.4 percent. Most dependents have been spouses. In general, few dependents are enrolled in MRMIP and the number of dependents

[3] Schauffler H., Ph.D., MSPH, Brown R., Ph.D., McMenamin S., MPH, Rice T., Ph.D Cubanski J., MPP. State of Health Insurance in California, 1998. Berkeley, CA. Regents of the University of California. 1999. p. 26

has decreased through the years. The insurance status of MRMIP subscribers' family members is unknown.

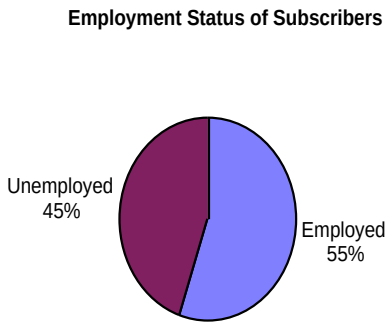


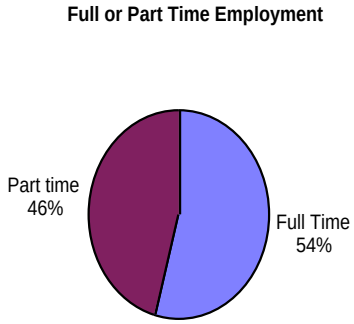
Source: MRMIP Enrollment Data, 1991-1999

There are few dependents enrolled in MRMIP because of the high premiums. Rates for dependents are based on the same risk assumptions used for subscribers. Therefore, premiums for dependent coverage is just as expensive as it is for subscribers.

Education and Employment

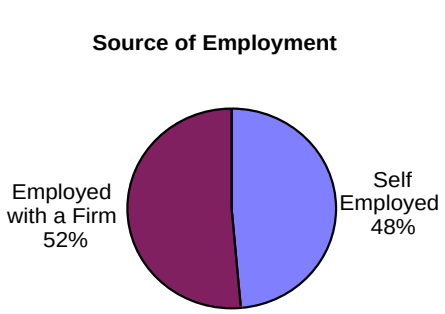
The vast majority, 91 percent, of MRMIP subscribers have a high school education or higher. Almost one-third have at least a four-year college degree. Most MRMIP subscribers (55 percent) are employed, and about half of these are self-employed.

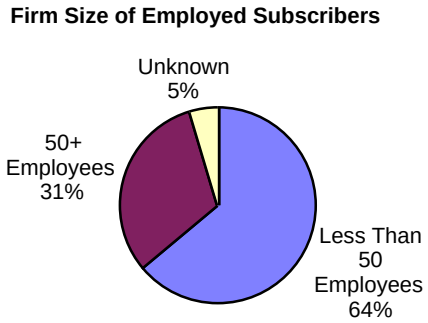




Source: MRMIP 1998 Independent Survey

Of those subscribers who are employed with a firm, 64 percent work in firms that have 50 employees or less. Most of the employed subscribers are employed full-time.

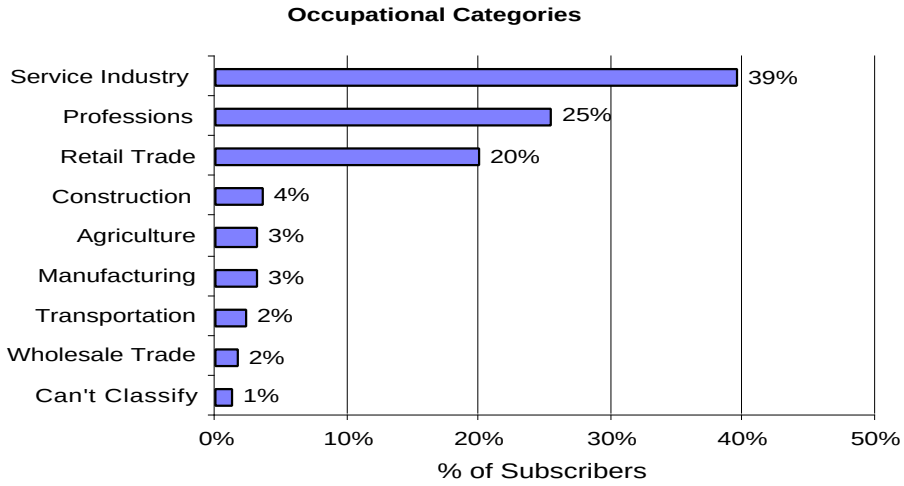




Source: MRMIP 1998 Independent Survey

Occupations of MRMIP Subscribers

Most MRMIP subscribers are employed in the retail trades, service industry or are professionals. The insurance industry considers the type of industry or firm as a factor in initial underwriting. Most insurers classify industries as preferred, substandard or excluded. These classifications are used to determine premiums, with higher premiums for substandard industries and lower premiums for the preferred. Many insurers consider automobile dealerships, hair salons, bars, car washes and restaurants to be substandard groups[4].



Source: MRMIP 1998 Independent Survey

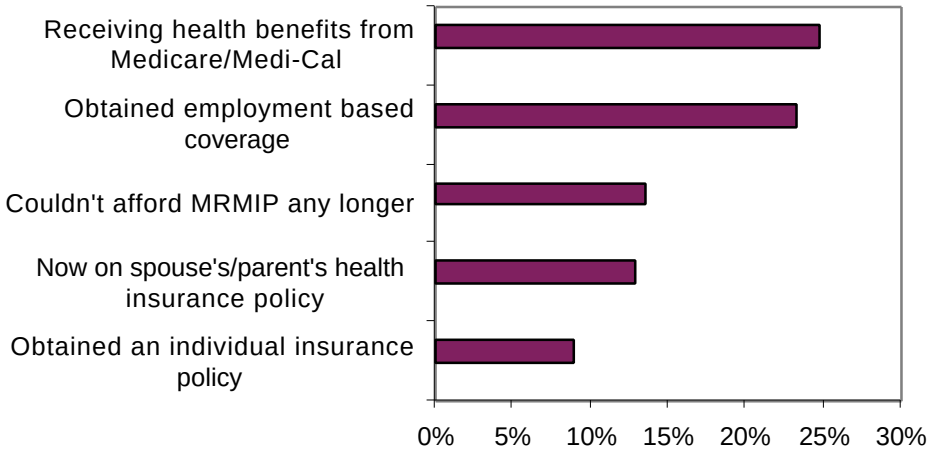
[4] Schauffler H., Ph.D., MSPH, Brown R., Ph.D., McMenamin S., MPH, Rice T., Ph.D Cubanski J., MPP. State of Health Insurance in California, 1998. Berkeley, CA. Regents of the University of California. 1999. p. 63-64.

Subscriber Disenrollment

In December 1998, a survey was conducted of subscribers who disenrolled from the MRMIP. All disenrolled subscribers (N=664) were surveyed. Thirty-nine percent (258 individuals) responded to the survey.

The most common reason for disenrollment was because MRMIP subscribers obtained other coverage. Twenty-five percent of subscribers became eligible for Medicare or Medi-Cal and received coverage through these programs. Twenty-three percent of subscribers obtained employment that offered employee coverage. Fourteen percent of MRMIP subscribers who disenrolled did so because they could no longer afford to pay the premium.

Reasons for Disenrollment From MRMIP 1998 (N=664)



Source: MRMIP 1998 Disenrollment Survey

A MRMIP subscriber sent the following letter expressing her appreciation for the MRMIP.

"You have protected me, guided me and helped me for more than a few years now when I was so ill that no one would help me with insurance. I feel like I am losing an old friend by canceling my insurance with you. My heart has strengthened and I am able to do some work now and am fortunate enough to be covered by my employer. Perhaps this will free up a space for another who is in big need as I was. I will always be thankful to your company and will spread the word on your efficiencies, compassion and help."

SERVICES PROVIDED THROUGH MRMIP

MRMIP provides comprehensive health care coverage through seven health plans. Two Preferred Provider Organizations (PPOs) and five Health Maintenance Organizations (HMOs) participate in the program. The PPO plans offer plan subscribers a network of providers from which subscribers can choose to seek care. The PPO plans also allow members to seek services from providers that are outside the PPO network, but at a higher cost to the member. Members enrolled in the PPO plans pay between 20 and 25 percent of the cost of medical services.

The HMO plans are organized health care delivery systems that provide a set of health care services to plan subscribers in a geographic area. In an HMO, a member chooses a primary care provider, or PCP, and uses network providers to receive care. These plans charge copayments for many services.

Most members are currently enrolled in PPOs. The table below shows the enrollment distribution across all participating plans.

Health Plan	% of Enrollees*	# of Counties in Which Plan is Available
Blue Cross of California, Prudent Buyer PPO	71%	Statewide
Kaiser Permanente, South	9%	6 Counties Partial Coverage in 5 Counties
Kaiser Permanente, North	7%	22 Counties Partial Coverage in 13 Counties
Blue Shield of California, PPO	7%	Statewide
Blue Shield of California, Access+ HMO	6%	30 Counties Partial Coverage in 12 Counties
Maxicare	0.3%	9 Counties Partial Coverage in 9 Counties
Contra Costa Health Plan	0.1%	1 County

*The total percentage of enrollees reported is over 100% due to rounding.
Source: MRMIP Enrollment Data, 1999

MRMIP Benefits

The MRMIP offers a comprehensive benefit package to subscribers. Subscribers have a maximum annual out-of-pocket expense of $2,500 per person or $4,000 per family, and have an annual benefit maximum of $75,000 or $750,000 per lifetime.

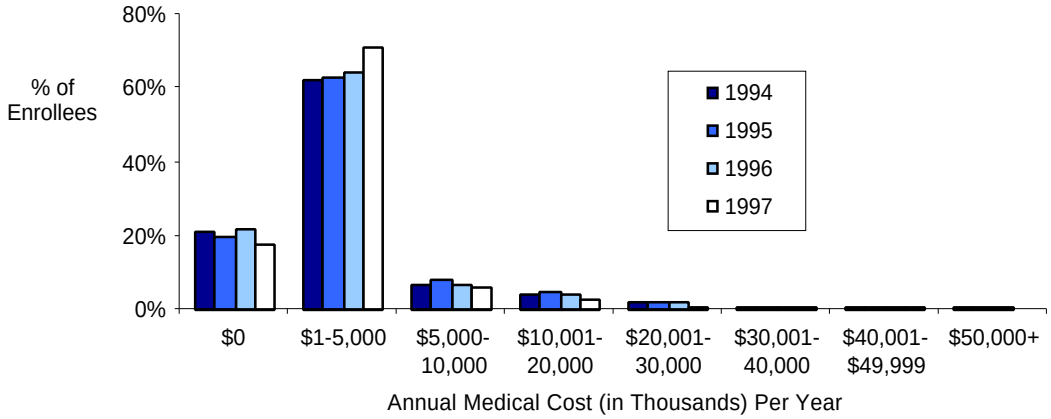
The benefit package includes:

TYPE OF SERVICE	DESCRIPTION OF SERVICE
Physician Care	Outpatient and inpatient physician services.
Hospital Services	Semi-private room & board, medically necessary impatient and outpatient services and supplies, and emergency hospital services as medically necessary.
Prescription Drugs	Medically necessary prescription drugs, drugs approved by the Federal Food and Drug Administration.
Diagnostic Test	Laboratory tests, x-rays and mammograms.
Durable Medical Equipment	As approved by the subscribers' health plan and required for care of an illness or injury.
Maternity Care	Prenatal care, inpatient delivery and complications of pregnancy.
Mental Health Services	As approved by the subscribers' health plan, up to 15 outpatient visits per calendar year and 10 inpatient days per calendar year.
Ambulance	Emergency transportation.
Speech/Physical/Occupational Therapy	As approved by the subscribers' health plan for short-term therapy for acute conditions.
Home Health Care/Hospice	As approved by the subscribers' plan.
Skilled Nursing services	As approved by the subscribers' plan.
Transplant Services	As approved by the subscribers' plan and includes corneal, human heart, heart-lung, liver, bone-marrow and kidney.

Source: Title 10, California Code of Regulations, Chapter 5.5, Article 3.

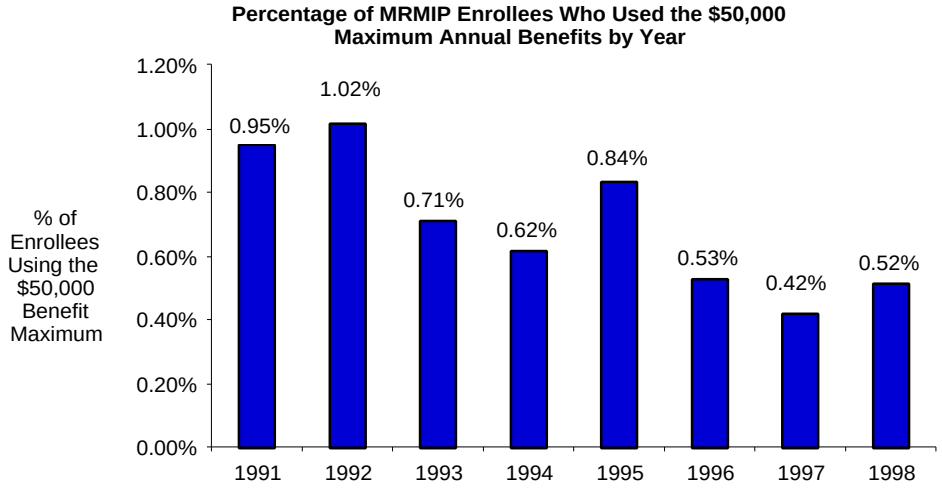
Medical Cost

The majority of MRMIP subscribers have medical costs of less than $5,000 per year. Since the program's inception in 1991, over 85 percent of all enrollees had medical costs that were below $5,000 per year. Approximately 20 percent of MRMIP enrollees make no medical claims each year, even though they have



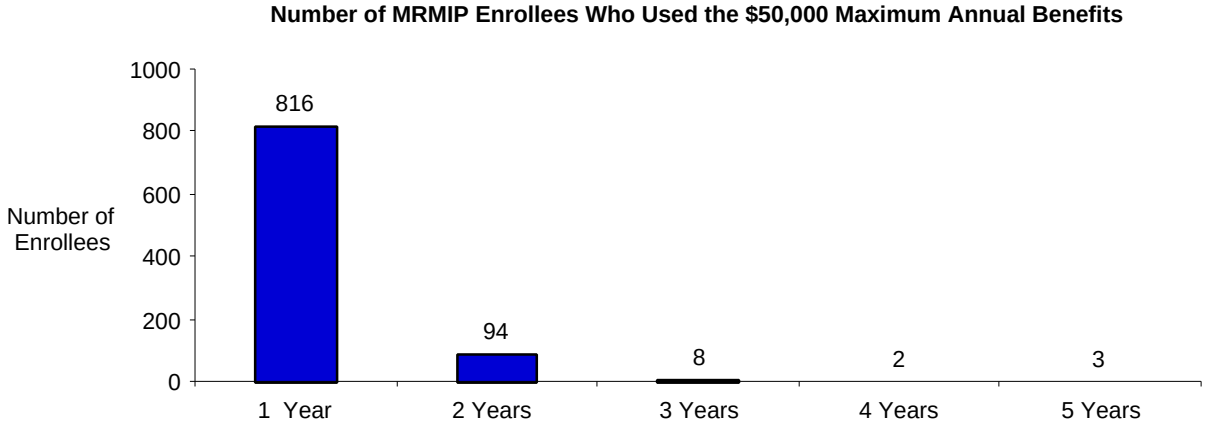
been determined to be uninsurable.
Source: MRMIP Medical Claims Data, 1994-1997

On average, 0.68 percent (seven-tenths of one percent) of MRMIP subscribers reached the program's $50,000 maximum benefit each year. The percentage of MRMIP subscribers using the $50,000 annual maximum benefit has ranged from a low of 0.42 percent in 1997 to a high of 1.02 percent in 1992. Beginning in January 1999, the annual maximum benefit is $75,000 per person.



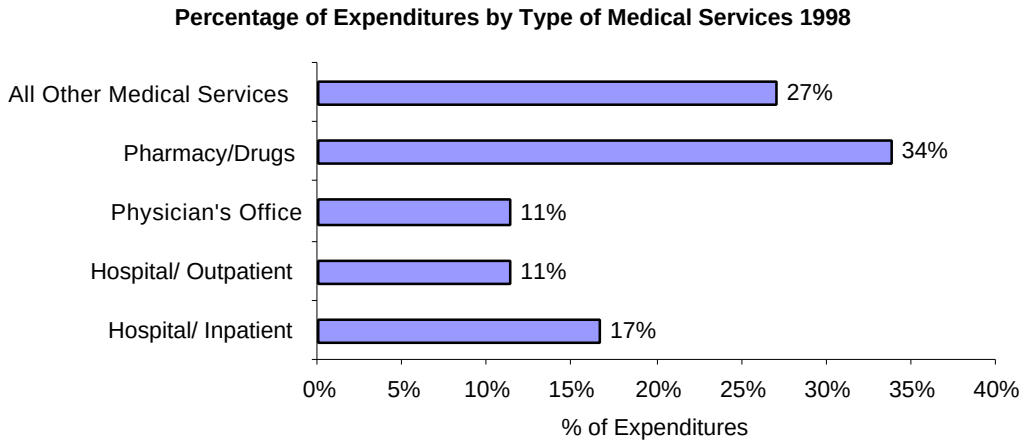
Source: MRMIP Medical Claims Data, 1991-1998

Only a small number of MRMIP subscribers reach the program's maximum annual benefit in more than one year.



Source: MRMIP Medical Claims Data, 1998

Thirty-four percent of program health care expenditures for 1998 were for prescription drugs. This is significantly higher than prescription drug expenditures in prior years, which were 22 percent for 1997 and 19 percent for 1996. Expenditures for hospital outpatient and inpatient services totaled 28 percent.



Source: MRMIP Medical Claims Data, 1998

MRMIP subscribers have a wide variety of medical conditions. The table below indicates the percentage of MRMIP subscribers with medical claims for the following 14 broad categories of illness. Percentages total more than 100 percent because subscribers may seek care for more than one condition during a year.

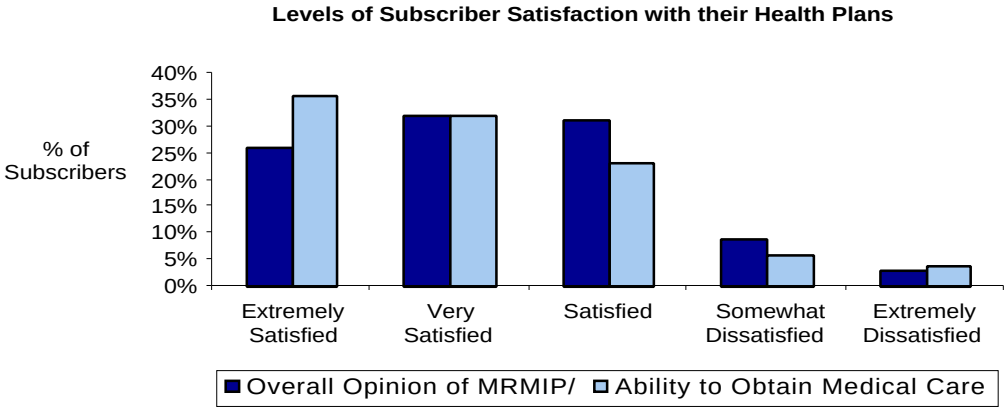
Percentage of MRMIP Subscribers with Selected Medical Conditions, 1997 and 1998

Disease Category	1997	1998
Disease of the Musculoskeletal System (examples include arthritis, rheumatism)	26.5%	23.5%
Diseases of Genitourinary System (examples include renal failure, infection of kidney, cystitis)	26.3%	22.6%
Nutritional and Metabolic Diseases (examples include thyroditis, diabetes)	25.8%	22.7%
Diseases of the Circulatory System (heart disease) (examples include hypertension, myocardial infarction, aneurysm, varicose veins)	25.6%	22.2%
Diseases of the Respiratory System (examples include pneumonia, influenza)	25.3%	21.0%
Diseases of the Nervous System (examples include bacterial meningitis, Alzheimer's disease)	24.9%	21.3%
Diseases of the Skin and Subscutaneous Tissue (examples include abcess, dermatitis)	16.9%	14.4%
Injury and Poisoning (examples include bone fractures, sprains)	16.9%	14.2%
Cancers and Neoplasms	15.8%	14.0%
Diseases of the Digestive System (examples include duodenal ulcers, gastritis, cirrhosis, of liver, diverticulitis)	15.3%	13.0%
Mental Disorders (examples include dementia, psychosis, depression)	11.2%	9.4%
Infectious and Parasitic Diseases (examples include AIDS, Tuberculosis)	11.0%	9.4%
Diseases of the Blood (examples include anemia, coagulation defects)	4.1%	3.8%
Pregnancy, childbirth and complications thereof	2.4%	1.9%

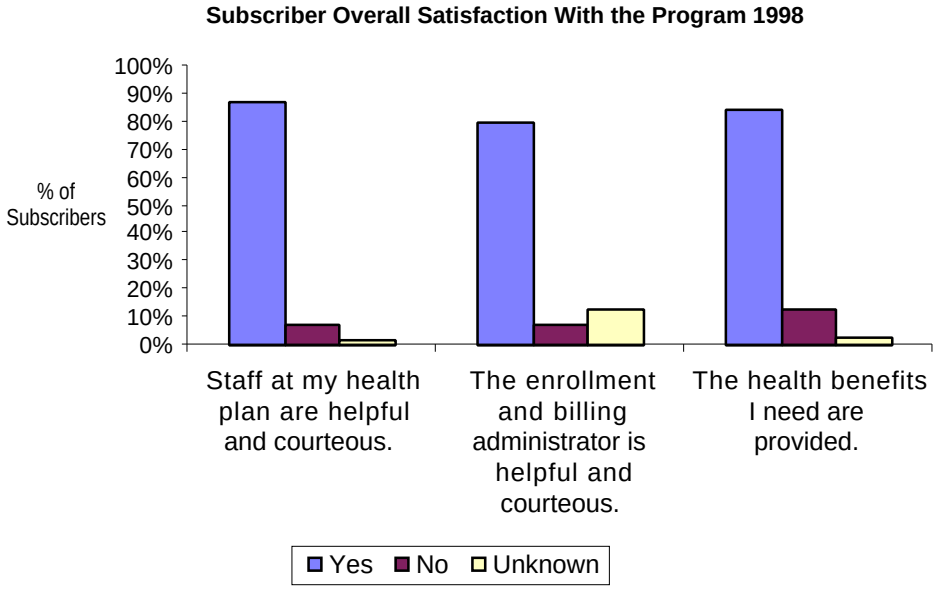
Source: MRMIP Medical Claims Data, 1998

MRMIP Subscriber Satisfaction

In August 1998, an independent survey was conducted to solicit subscribers' satisfaction with the program. Subscribers indicated that they were satisfied with the benefit package offered by MRMIP. They also reported high satisfaction levels with the program, their health plan, and their ability to obtain medical care. Ninety-three percent of subscribers were satisfied with their ability to obtain medical care through the program. Eighty-four percent of subscribers were satisfied with the MRMIP program overall. Eighty-nine percent of subscribers were satisfied with their health plans. Eighty-four percent of the subscribers who responded to the 1998 MRMIP survey stated that they were extremely satisfied with the health benefits the program provides.



Source: 1998 MRMIP Independent Survey



Source: 1998 MRMIP Independent Survey

DATA AND INFORMATION SOURCES

There are several sources of data and information that were used to compile this report. Information was obtained from MRMIB contractors and internal program reports.

The MRMIB contractors providing information for this report include:
- Blue Cross of California, the MRMIP enrollment contractor
- PricewaterhouseCoopers LLP Inc. (managed the independent survey of MRMIP subscribers through a subcontractor) *
- Participating health plans

The internal program reports used for this report include:
- The MRMIP Enrollment Data
- MRMIP State Cash Flow Analysis, for FY 1998-99
- 1998 MRMIP Disenrollment Survey

Other sources of information used in this report include:

Schauffler H., Ph.D., MSPH, Brown R., Ph.D., McMenamin S., MPH, Rice T., Ph.D Cubanski J., MPP. State of Health Insurance in California, 1998. Berkeley, CA. Regents of the University of California. 1999.

Communicating for Agriculture. The Comprehensive Health Insurance for High-Risk Individuals, Twelfth Edition, Inc. 1998.

*On August 1998, a total of 405 MRMIP subscribers were surveyed to solicit their views on the MRMIP and to obtain more detailed demographic information on subscribers. The survey was conducted via phone calls to the subscribers' homes in the evenings and weekends. Individuals included in the survey were randomly selected from a current list of subscribers. The sample was stratified by health care delivery system type to provide representative data on subscribers enrolled in Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs).

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